Today's Date: _____

Date Due _____
(10 days)

EMPLOYER INSURANCE VERIFICATION

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE
HIPP Program (Health Insurance Premium Payment)
600 E. Broad Street, Suite 1300
Richmond, VA 23219
(804) 225-4236

The State of Virginia is considering paying the health insurance premium on behalf of the employee listed below, in accordance with Section 1906 of the Social Security Act. Any information provided on this form will remain confidential. In order to help us make a determination, **please return this form within 10 days.**

PART A - MEMBERSHIP **Employee**	**SS#**	**Birthdate**	**Eligible for health plan** ☐ yes ☐ no **Currently enrolled in plan** ☐ yes ☐ no

Dependents	SS#	Birthdate	Relationship	Eligible for health plan	Currently enrolled in plan
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no
				☐ yes ☐ no	☐ yes ☐ no

PART B - ELIGIBILITY

1. Employee Status ☐ full time ☐ part time
2. Is this employee eligible for coverage under your company's group health plan? ☐ yes ☐ no
   (if "no", reason: _____)
   (if "no", fill out PART E only and return)

PART C - COVERAGE

1. If the employee is currently enrolled, what is the type of coverage?

   ☐ **Employee Only** ☐ **Employee Plus Child** ☐ **Family**

   Effective Date _____

2. If the employee is not currently enrolled, when can enrollment occur?

   ☐ **Open Enrollment Dates: From** _____ **To** _____
   ☐ **After employment period is met (date eligible** _____)
   ☐ **Any time**

PART D - PLAN BENEFITS

Please indicate benefits for each group health plan available to the employee. If more than 2 plans are available, use additional forms.

Name and Address of Insurance Company

_____

_____

_____

Name of Plan _____

Premium Information
(employee's portion only)

Coverage (please fill out all plans)	Premium Amount	How Often
Employee Only	$_____	☐ Weekly
Employee + Child	$_____	☐ Every Two Weeks
Family	$_____	☐ Monthly
		☐ Quarterly

Type of Plan:

- ☐ HMO
- ☐ PPO
- ☐ Hospital Only
- ☐ Comprehensive/ Major Medical

Services Covered:

- ☐ Inpatient Hospital
- ☐ Outpatient Hospital
- ☐ Physicians
- ☐ Home Health
- ☐ Lab/XRay
- ☐ Drugs
- ☐ Dental

Pre-existing conditions excluded?	☐ yes	☐ no
Dependent maternity excluded?	☐ yes	☐ no
Waiting period for maternity?	☐ yes	☐ no
How long _____		

Name and Address of Insurance Company

_____

_____

_____

Name of Plan _____

Premium Information
(employee's portion only)

Coverage (please fill out all plans)	Premium Amount	How Often
Employee Only	$_____	☐ Weekly
Employee + Child	$_____	☐ Every Two Weeks
Family	$_____	☐ Monthly
		☐ Quarterly

Type of Plan:

- ☐ HMO
- ☐ PPO
- ☐ Hospital Only
- ☐ Comprehensive/ Major Medical

Services Covered:

- ☐ Inpatient Hospital
- ☐ Outpatient Hospital
- ☐ Physicians
- ☐ Home Health
- ☐ Lab/XRay
- ☐ Drugs
- ☐ Dental

Pre-existing conditions excluded?	☐ yes	☐ no
Dependent maternity excluded?	☐ yes	☐ no
Waiting period for maternity?	☐ yes	☐ no
How long _____		

PART E - EMPLOYER'S REPRESENTATIVE: I hereby certify that all information contained herein is true and is correct to the best of my knowledge.

Group Administrator for Health Insurance Plan _____

Employer _____

Employer's Address _____

Department _____

Phone # (_____)_____

Signature _____ **Date** _____

attach business card if available

DMAS - 502 3/95